LOGIC MODEL for LA-YES

1. (Stage 1) Forming a Workgroup

Workgroup formation has been crucial to the development of the LA-YES Logic Model. Agency partners and parents/family members have met in workgroups to develop various aspects of the Logic Model Goals, Population, Outcomes, Indicators, and Strategies. This approach has been conceptualized on three levels: practice, bridge and system.

Practice level workgroup formaiton has included parents and family members. During the initial Consortium meetings prior to the awarding of the LA-YES Cooperative Agreement, Goals were chosen and agreed upon. During three service delivery committee meetings, segments of the LA-YES target Population were conceived. Finally, during three well-attended meetings, parents endorsed and further developed segments of the Population and Outcome stages. Other practice level collaborations included an Office of Community Services (OCS) workgroup, an Office of Youth Development (OYD) workgroup, a Children's Hospital workgroup, medical school workgroups (Tulane University School of Medicine, LSU School of Medicine), and an Office of Mental Health (OMH) workgroup. These workgroups helped develop Population, Outcome, Indicator, and Strategy stages.

The bridge level consists of partners who helped LA-YES devise strategies and approaches that link practice and system levels. The agency partner and parent workgroups described in the previous paragraph also served bridge level functions. In addition, meetings with the directors of New Orleans Adolescent Hospital, Jefferson Parish Human Services Association, Pyramid for Parents, Louisiana Office of Public Health, Excelth, and the Metropolitan Services District were very helpful in developing a direction for the unfolding of the Logic Model planning.

System level meetings and workgroups helped define system level Population needs and Outcomes. Meetings with Medicaid administrators with the Louisiana Department of Health and Hospitals (DHH) were instrumental in the articulation of reimbursement needs and Outcomes. Evaluators and state agency administrators helped define system level Outcomes and Indicators, as well as Strategies. Parish and state Interagency Service Coordination administrators were essential in the development of many system level Outcomes. Multiple meetings with LA-YES staff and teleconference meetings with Dr. Hernandez and Dr. Hodges (University of South Florida) were very helpful in the direction of the process and the creation of this document.

2. (Stage 2) Mission

It is the LA-YES mission to enhance the well-being, especially the emotional well-being, of children and adolescents in the target area (with varying degrees of severe emotional disturbance) by creating and implementing intensive community-based services for the target population based on a collaborative, multi-agency, multi-disciplinary approach.

3. (Stage 3) Goals

The goals articulated in this section represent the shared views of the LA-YES partners, including family members (of children and adolescents with needs consistent with those of the target population) and workers within both public and private agencies (whose stated missions revolve around providing services to the target population). The goals are organized within three contexts: program, youth/family, and system. Each context represents a level at which change must take place to ensure that meaningful improvement occurs in the lives of (those members of) the target population. The program level represents all of the practices necessary for the literal provision of services, including planning, the actual services and the provision of those services (from referral through discharge), and measurement of outcomes. The youth/family context represents the group to whom the services will be offered. The system context consists of those non-practice elements that provide the necessary infrastructure for LA-YES program development and implementation.

Program context goals are created and chosen to serve as guidelines for the development of actual LA-YES practices. They call for action that ensures early intervention and prevention of emotional and behavioral problems. This mandates the inclusion of two groups of individuals not usually served by the current service delivery systems within Orleans Parish: preschool children (3 to 7 years of age) as well as individuals with a moderate level of need (CALOCUS levels 1 and 2). The inclusion of both groups provides elements of prevention. Helping to remediate early problems in the very young can mitigate the development of more entrenched and more complicated disturbances in later life. In addition, offering helpful treatments for moderately incapacitating emotional problems is successful often in containing those problems (and, thus, in mitigating the need for later, more expensive treatments).

With the mission statement in mind, LA-YES program context goals seek to reconfigure how services are actually planned and delivered. Providing culturally competent and sensitive services is a priority for LA-YES. Cultural competence is a key to family inclusion. Families should be involved at every level of service delivery, including planning and decision-making. The LA-YES program should offer an array of services broad enough to satisfy the needs of the clients. It should consist of the latest, proven (evidence-based) treatments and best practices.

Program context goals include the call for the development of outcome strategies. Outcomes and measures should provide feedback about how the program is functioning and should be incorporated into program monitoring so that it informs future action (ie, change at the program level).

The youth/family context presents addition opportunities for goal development. Practices should help reduce symptoms and negative behaviors that lead clients/families to seek services. Reducing symptoms and negative behavior frees the youth to participate in prosocial events and to contribute to those events. Functioning within daily domains (eg, home, neighborhood, school) and special settings (juvenile justice) should improve in

measurable ways. Parents, caregivers, and family members should also experience fewer stressors and demonstrate improved functioning. Family improvements should be measurable and measured.

Conceptualizing goals in the context of system change and development provides additional opportunities to involve families. Planning at all levels should be family-driven, including governance of LA-YES and sustainability planning. Further, the system should provide expanded access for the target population, especially for those sectors of the community where the greatest need exists. The changes in the way care is provided to the target population by the LA-YES care delivery system should be measured and reported. Outcome is important at the system level, just as it is at the program and youth/family levels. Public education should be an additional goal of LA-YES. Community awareness of child and adolescent mental health needs and problems should be targeted. The outcome of education efforts, which also should address directly the stigmatization associated with mental illness, should be measured.

System level goal formation should affect infrastructure development in multiple ways. It is central to the success of LA-YES that partner agencies come together to work collaboratively at the system level so that coordinated (ie, non fragmented) services can be offered at the program level. Such collaborations offer potential resource brokering and pooling. Further, system changes in reimbursement mechanisms are necessary to provide the type of clinical services that can fulfill the promises implicit in LA-YES values and to be consistent with stated principles (next paragraph).

Guiding principles have emerged as goals have been created. These principles connect LA-YES values to the specifics of care plan development and they reflect the overall principles of system of care. They promote family-focused, individualized, community-based, and culturally competent service development that is accessible. Services are coordinated among child serving agencies and are provided in the least restrictive (appropriate) setting.

- **a. Program Context**
  - **i.** A comprehensive program (system of care) for the target population(s) within Orleans Parish will be developed. The program will include appropriate intake portals and procedures designed for the early intervention and prevention of emotional and behavioral problems
    1. The comprehensive program (system of care) will facilitate the provision of a broad array of mental health and other related services, treatments, and supports for the target population
    2. Evidence-based practices will be generalized to the target area/population. Best-practices regarding planning will be incorporated into program development.
    3. Culturally competent practices for serving the target population in each funded community will be incorporated into the developed system of care

4. The system of care that is developed will include services designed to treat the portion of the target population with more moderate (but nevertheless functionally incapacitating) level of care (LOC) needs

ii. Families will be involved at every level of service delivery, including planning and decision-making

iii. Program effectiveness will be evaluated and results will be utilized in the review and redesign of programs

b. Youth/Family Context

i. Youth who are served will demonstrate reduced symptoms and negative behaviors and improved functioning in multiple domains

ii. Caregivers will experience reduced stress and families will demonstrate improved functioning.

c. System Context

i. The community (target population and their families) will be involved in all levels of the system (planning, governance, and service delivery)

ii. Access to services will be increased for the target population in Orleans Parish

iii. Partner agencies will work collaboratively at the system level so that coordinated (ie, non fragmented) services can be offered at the program level

iv. The effectiveness of the system of care and its component services will be evaluated

v. Reimbursement practices (for mental health services provided for the target population) will encourage programs to develop and implement helpful (to the target population) practices

vi. The system will work to increase awareness in Orleans Parish that mental illness does affect children/adolescents and to decrease the stigma and socio-cultural barriers associated with mental illness and mental health care.

vii. System of care practices will be transported to the 59 LA parishes not included in LA-YES

4. (Stage 3, continued) Guiding Principles

a. All services and supports should consider the needs and strengths of the entire family. Youth/families should be the bottom-line decision-maker at the level of planning and actual service delivery.

b. Services and supports should be designed in accordance with the strengths and needs of each individual served. Youth/family needs should guide planning, but implementation of plans should be predicated/based on youth/family strengths.

c. Services and supports should be sensitive and responsive to the cultural characteristics of children and their families

d. Service planning should balance child/family need to interact in school and community settings with the most appropriate services and supports.

e. Services and supports should be provided in the child/family's community

f. Access to services and supports should not be limited by location, scheduling, or cost
g. Core agencies providing services and supports should include mental health, OCS (child welfare), juvenile justice, and education
h. Partner agencies, providers and organizations should provide a seamless system of services and supports for children and families

5. (Stage 4) Population

Studying the target population provides an opportunity to understand both strengths and needs of program development, individuals and their families, and the systems that will support the delivery of services. The LA-YES mission has been developed in response to the conditions described within each context. The contexts, themselves, exist within cultural, political, and economic frameworks that influence and contribute to the strengths and needs of each context.

Orleans Parish and Louisiana have rich heritages that provide the foundation for the local population. French explorers founded both in the late seventeenth century and settlements were established shortly afterward. New Orleans served as a cultural center and major port for the region and later for the US, beginning in the mid eighteenth century. The area changed hands from the French to the Spanish and back again until the entire area known as Louisiana was purchased by the United States in 1803 from Napoleon. New Orleans grew quickly during the second half of the eighteenth and first half of the nineteenth centuries and became home to Americans, French and Spanish settlers, individuals of Creole decent, and Africans brought to the area by slave traders. Following the Civil War and Reconstruction, New Orleans settled into a pattern of cultural, political, and economic functioning similar to other southern metropolitan areas. It was economically dependent on agriculture and shipping and was politically very conservative. African-Americans, though no longer held in slavery, were disenfranchised (economically and politically). That pattern continued well into the late twentieth century, when changes within American society began to impact the situation in Louisiana and New Orleans. During the 1960s and 1970s schools were integrated and the African American voice began to be heard politically in Orleans Parish. Those developments were attended by demographic changes in the region as the (here-to-fore) traditional majority began to move from New Orleans to suburban parishes. (This process continues today.) The African American political voice grew and early in the 1980s New Orleans elected its first African American mayor. Today, the population of Orleans Parish is 67% African American, 27% Caucasian-European decent, 3.1% Hispanic, and 2.9% Vietnamese American.

The economic situation in Louisiana and Orleans Parish has not developed as vigorously during the past few decades as it has in other parts of the country. The economy of the state has traditionally depended on agriculture and petroleum. The local petroleum industry began to falter during the 1970s when it started the slow (and not-so-slow) move from New Orleans to other areas, especially Houston. The move out of Orleans Parish continues today. Some of the petroleum loss has been mitigated by the shipping industry

and the burgeoning tourism industry, but both Orleans Parish and Louisiana have substantial impoverished subgroups. Estimates suggest that 25-30% of individuals in Orleans Parish are classified "below poverty level." The usual problems attend this economic situation: unsatisfactory health care outcomes, education and education system problems, and over involvement of the LA-YES target population with juvenile justice and child welfare. Crime and violence are problems faced disproportionately by the LA-YES target population and their families.

Despite the challenges implicit in the economic and political climates, both Louisiana and Orleans Parish have great strengths. African American, French, Spanish, and Vietnamese cultures flourish throughout the state and parish, contributing to and enlarging the scope of the Louisiana experience. Everything from food to language to the law is different here. Louisiana has its own identity, based on the collective experiences of its citizens, that is set apart from the rest of the United States. Many in Louisiana would say that this is its greatest strength.

Orleans Parish strengths are seen and heard almost everywhere in the city. Millions of visitors come to the city each year because of those strengths. However, the primary strength of the city is its people. The fact that New Orleans has produced so many nationally and internationally known figures makes it clear that the conditions here are such that individuals within the LA-YES target area can develop in extraordinary ways. There is no quick way to catalog all of the person-based assets in the city, much less the total assets of the city.

One local strength that bears mention is the (somewhat) recently organized collaborative efforts among child serving agencies in Orleans Parish to reconfigure the delivery of care for special populations. LA-YES and Reclaiming Our Futures (a workgroup with a juvenile justice-enhancement mission spearheaded by Baptist Community Ministries) are examples. The energy, enthusiasm, and experience of the participants are helping bring about needed change and serve as explicit examples of our local strengths. These collaborations are successful because they are supported at multiple levels of various child and adolescent service delivery systems including state government. **A collective understanding is developing: substantive change must take place within system and program contexts in order to sustain improvements (which might be made) in the youth/family population context.** That understanding is driving this constructive period of health care service delivery infrastructure growth in New Orleans and in Louisiana.

Needs provide the motivation for change. For our purposes, they are best understood within the same contexts used to articulate goals. Although described before population, goals are based on needs described within the population contexts. Strategies and outcomes are developed in response to needs.

Program context needs describe challenges noted in current practice. Orleans Parish children and adolescents with moderate level of care needs who are nevertheless functionally impacted (by those needs) and still considered to have a serious emotional disorder (SED) are not served in the current local systems. Generally, programs and

practices have utilized traditional planning and therapeutic methods and techniques. Evidence-based treatments and best practices often are not incorporated into service delivery. In addition, families have been excluded generally from decision-making during treatment planning and its implementation. There is usually a limited opportunity to choose treatments from a fulsome list of potential therapies because there is an insufficient array of services. Restrictive settings are often more available than more effective, less restrictive methods. More often than not, local treatment practices have not been data-driven. Measurement of outcomes has not been emphasized and has not guided practice development.

Youth/family context describes the actual group of individuals for whom LA-YES is designed. This level includes those who are eligible for services as well as special populations within the eligible group who demonstrate particular needs that are traditionally served by systems of care. Eligibility is extended to those children/adolescents/young adults (3-21 years of age) with serious emotional needs (as defined by DSM 4) whose level of functioning within the family, school, and/or community environments is negatively impacted (by the aforementioned serious emotional needs). Functional incapacity must be present for one year (or expected to last for at least one year). Although prevalence studies at this time are incomplete, the Louisiana Department of Health and Hospitals estimates that there are over 11,000 children and adolescents in Orleans Parish who are eligible for LA-YES services (ie, target population). Based on national prevalence models, 5,500 are thought to suffer with moderate (SED) needs (CALOCUS levels 2-4; LA-YES levels 1and 2); 5,500 are thought to suffer with higher levels of need (CACOLOCUS levels 5 and 6; LA-YES levels 3 and 4).

Special populations include individuals within the LA-YES target group who are involved with **juvenile justice** in Orleans Parish. Formal sectors of juvenile justice include FINS (Families in Need of Services, a court-based monitoring system for children/adolescents who have committed status offenses), Arrest/Detention, Pre-trial, Informal Adjustment Agreement, Post Adjudication, and Corrections. Each year the New Orleans Police Department arrests 12,000-14,000 children and adolescents for status offenses and 7000-8000 children and adolescents for delinquent offenses. Most of the status cases are handled without court or formal district attorney involvement. Approximately 1400 status cases are referred to FINS each year. Slightly over half of those are referred because of truancy. During the course of the year, there are approximately 700-800 active FINS cases, of which 400 are truancy cases. Of the 7000-8000 arrests per year for delinquent violations, over 6000 plead guilty and are subsequently placed on probation, inactive probation, in a program (Teen Court, Drug Court, Weekend Detention) or they are remanded for secure care. There are 800 open cases (of youths arrested for delinquent crimes) and 300-400 trials per year.

The Office of Youth Development (OYD) operates three major program areas: Corrections/Secure Placement, Probation, and Parole. Orleans Parish OYD has a current caseload of about 900 clients. The great majority are children and adolescents within the Probations Program (remanded to OYD by the Courts with suspended sentences in lieu of

being placed in a secure facility). Secure Placement (Corrections) includes three juvenile correctional facilities in Louisiana. The number of children and adolescents incarcerated has diminished during the past year because of an effort on the part of Corrections officials to release youths as soon as possible. Currently there are ~400 youths with severe emotional disturbances in the three facilities. A small percentage of those are Orleans Parish youths. Although mental health care is well provided in the facilities by the LSU Juvenile Corrections Program, discharge and follow-up services for released children/adolescents have been inadequate and (most) often not available.

The LA-YES juvenile justice partners identify three areas of need: Post-adjudication, FINS, and Corrections. (District Attorney's Diversion Program had been identified as an area of need during the DA's initial meeting with LA-YES. During recent meetings, however, LA-YES was asked to focus program development within the areas of FINS and Post-adjudication). The primary concern identified by the New Orleans District Attorney's office was the lack of juvenile forensic facilities for children/adolescents found to be non functional and incompetent because of mental illness.

Children and adolescents in the custody of the **Office of Community Services (OCS)** represent another special population. OCS operates four major program areas: Child Protection Investigation (CPI), Foster Care (FC), Family Services/In home services (FS), and Adoptions (AD). The caseloads for 2003 are detailed in the following table:

Orleans Parish OCS Caseload Statistics for 2003		
Program Area	**Number Served**	**Comments**
CPI	2,686	# of families investigated
FC	9,277	# of youths in workers' caseloads/month; a single youth will be counted more than once if he/she is in foster care more than 1 month
FS	2,631	# of families served
AD	1,565	# of youths freed/waiting for adoption

The FC and AD programs utilize the vast majority of OCS mental health treatment funds. All children served by OCS receive a mental health assessment within 30 days of commencing care to determine if additional mental health services will be needed. Currently, OCS has a contract with LSUHSC to develop and maintain a panel of credentialed providers who offer mental health services to their clients. However, this system will be discontinued in December, 2004, and a replacement system has not been chosen yet. The greatest stated mental health need within the OCS system is for timely psychiatric evaluations. The current wait is four to six weeks.

Children and adolescents treated through **Children's Hospital and Clinics** are a third special population. The total number of outpatient visits to Children's Hospital and Clinics in 2003 was 132,154. The major Orleans Parish clinic is the Napoleon Pediatrics clinic, which treated 40,637 children and adolescents in 2003. Of those, 11,710 were considered to have "special needs," including approximately 600 patients with psychiatric needs. Children's Hospital clinicians say that the greatest psychiatric need

revolves around finding child psychiatrists to evaluate and treat their clients. About half of the 600 identified patients with psyciatric needs have moderate LOC needs (primarily ADHD) and half have more serious needs (behavioral problems, anxiety, depression). Children's Hopsital administrators have asked for LA-YES assistance in the Napoleon Clinic with children and adolescents with both moderate and severe LOC needs. (Based on national prevalence figures, the percentage of Children's Hospital outpatients with psychiatric needs is probably far greater than the number identified in the figures presented in this paragraph.)

Children and adolescents seeking services in the current **public mental health system** in Orleans Parish represent a fourth special population. The four clinics treating youths receive approximately 1250 referrals per year. Of those, approximately 750 are admitted for services. Attempts are made to refer most of the remaining 500 cases, but few options are available for those children/adolescents whose moderate LOC needs warrant psychiatric services.

System context needs point out areas where infrastructure changes are necessary to sustain changes in the other contexts. Local and state systems have rarely been sensitive to cultural or family issues in ways that truly promote family-driven approaches. Parent involvement at all levels of planning is a critical piece of infrastructure development that is usually missing. In addition, a major problem with current care is the lack of access the LA-YES target population has to care and services. The Louisiana Department of Health and Hospitals estimates that only six percent of severely emotionally disturbed children and adolescents has access to mental health services in Orleans Parish.

The system context is broad, including related areas that indirectly impact the LA-YES mission. The first is the fragmented nature of mental health services throughout Louisiana and Orleans Parish. Funding sources for therapies are agency-specific. Agencies do pool resources, but not very often. In short, funding does not follow the child. The second broad issue also relates to funding. Target area providers view Medicaid (and other reimbursement processes for mental health services) as insufficient. Both the reimbursement schedule and the process for reimbursement present problems for clinicians and agencies. The third area of concern regards public knowledge about mental illness in the target population and stigmatization of mental health issues. There is a general public unawareness that mental illness affects children/adolescents and stigmatization of mental illness continues. Further, there is a general public unawareness of community/advocacy supports and services. In addition, LA-YES target population parents are often unaware of how to advocate for their children and families.

1. **Program Context**
    - **i.** Practices have utilized traditional planning and therapeutic methods/techniques without incorporating current evidence-based and best practice approaches (in planning and treatment)
    - **ii.** Families have generally been excluded from decision-making and planning at the service delivery level

iii. Measurement of outcomes has not been emphasized and has not guided practice development
iv. Prevention and early intervention have not been emphasized
v. Services are denied to those individuals with more moderate LOC needs who are nevertheless functionally impacted (by those needs) and still considered to have a serious emotional disorder (SED).
vi. There is an insufficient array of services. Restrictive settings are often more available than more effective, less restrictive methods.

b. Youth/Family context

i. The target population for this first phase of the implementation of LA-YES services consists of children and adolescents (3-21 years of age) exhibiting a functional incapacity secondary to a DSM 4 diagnosis living in Orleans Parish.
ii. Subgroups of most concern in Orleans Parish include:
    1. Eligible children and adolescents within the juvenile justice system. Three areas in particular have been identified within the juvenile justice system (~20% of LA-YES children and adolescents)
        a. Eligible children and adolescents identified by the courts
        b. Eligible children and adolescents identified by FINS
        c. Eligible children and adolescents released from Corrections
    2. Eligible children and adolescents identified within the school system (~20% of LA-YES children and adolescents)
        a. NOTASC
        b. Social Work Department within Orleans Parish Public School System
    3. Office of Community Services (OCS) (~20% of LA-YES children and adolescents)
    4. Children's Hospital and Clinics (~10%)
    5. Mental Health Center system (~20% of LA-YES children and adolescents)

c. System Context

i. Racial and ethnic disparities exist in the delivery of services to the target population
ii. Family and community involvement have been excluded from system planning, governance, and many aspects of service delivery
iii. There is a critical lack of access to services for the target population
iv. Services are fragmented and funding for services does not "follow the child"
v. Medicaid and other reimbursement processes for mental health services are often viewed by target area providers as insufficient.
vi. There is a public unawareness that mental illness affects children/adolescents and stigmatization of mental illness continues. There is a gereral public unawareness of community/advocacy

supports and services. In addition, LA-YES target population parents are often unaware of how to advocate for their children and families.

vii. System of care principles have not been introduced to the other 59 LA parishes not included in LA-YES

6. (Stage 5) Map Resources and Assets

Asset/resource mapping is an exercise that reveals existing community supports that provide services to the target population within the target area. The mapping process includes the listing of services used by partner agencies and group members, as well as those researched by LA-YES staff. The services included in the mapping are those provided by both public and private agencies.

Because asset mapping is a process that continuously revises and updates the contents of the map, and because of the number of elements contained within the map, it will not be listed here. However, at this point in its development, the map contains over 180 services provided by agencies to children and adolescents living within Orleans Parish.

Based on the identified assets, services and supports have been listed under the following headings/categories. (The numbers in parentheses represent the number of services currently offered within the target area to children and adolescents.)

A) Mental health care (12)
B) Health care (11)
C) Services for those with MR-DD needs (9)
D) Substance use (11)
E) Supports
    - General (2)
    - Employment (4)
    - Education (56)
    - Care (19)
    - Recreation (18)
    - Housing (4)
    - Residential (11)
    - Financial (3)
    - Monitoring (16)

The greatest number of identified services regards education support, most often in the form of tutoring after school. Of the 12 identified that provide mental health care, most are public agencies. The private agencies providing mental health care are designated, not-for-profit. Each offers services for a fee, although most provide a sliding scale option.

7. (Stage 6) Assess System Flow

This stage of the Logic Model provides information about the numbers of children and adolescent who move through the service system, the timing of their flow, and identification of critical decision points.

The most critical element of this stage as it pertains to Orleans Parish regards the flow of children and adolescents through the service system provided by the Office of Mental Health and the newly created Metropolitan District Authority (providing non mental health center services to children and adolescents in Orleans, Plaquemines, and St Bernard parishes). The flow through these systems reveals the needs of the target area more than it provides evidence of its streagths. The reason for this is the non-coordinated access to the two systems. OMH, through Region 1 and New Orleans Adolescent Hospital, provides the administration for the four parish mental health centers that treat children and adolescents. The Metropolitan District provides the administration for related services, including cash subsidy (48 current clients) flexible funds, Family Preservation (50 clients/year), planned respite, and case management (for homeless families). The different modes of access into the two systems means that clinical and administrative teams making decisions about youth/family needs within the mental health centers cannot readily access the services offered through the Metropolitan District Authority. Currently, children and adolescents within one system must formally apply for services within the other system. This has created a process with huge seams (ie, non seamless) that contributes to delays in service delivery. Data that describe the movement between the two systems are not readily available. In addition, data detailing how many of the 750 children and adolescents admitted to the four mental health centers per year also receive services from the Metropolitan District are also not available.

The flow within each of the systems described in the previous paragraph (mental health center and Metropolitan District system) is consistent with that found in most public systems. Potential clients phone for services (to each agency). Information is collected and eligibility is determined in subsequent agency meetings. This general mechanism also describes the intake process utilized by most of the agencies providing services and supports listed in Stage 5. Most agencies use wait lists when capacity has been exceeded. The usual problems that attend wait lists are readily noted in Orleans Parish.

The strengths implicit in the systems flow described in the previous paragraphs include the availability and provision of necessary services to the target population. The system works best for those clients with major psychiatric and behavioral problems. However, there are obvioius problems. For well over half of clients, services are not available or are not readily available. Even those clients with severe LOC problems experience major difficulties accessing needed services; those clients with moderate LOC needs experience great difficulties accessing services.

8. (Stage 7) Outcomes/Indicators

Outcome development provides an opportunity to articulate a successful end-point for the goals. Each goal must be represented in the outcomes. Indicators provide the mode for measuring outcomes. They are the tangible/quantifiable proof that the outcomes have been achieved. Outcomes and indicators are divided into the same contexts as population and goals: program, youth/family, and system contexts. In addition, each outcome and

indicator context is divided into short-term and long-term, because some outcomes of goal development occur quickly while others take more time.

Short-term program context outcomes describe the end point of the planning process. In short, they articulate the incorporation of system of care values and principles into program strategy development. Specifically, they clarify that evidence-based and best-practices approaches, family involvement, services to younger clients, culturally competent practices, and evaluation efforts have been incorporated into planning. An additional program short-term expectation is the completion of the ISP Practice Model. The indictors substantiating this outcome include the completion of the Logic Model and the development of LA-YES Policies & Procedures that are consistent with system of care values and principles.

Long-term program context outcomes concern the structure and implementation of clinical services. They create the expectations that all strategies developed to achieve stated goals will incorporate system of care values and principles. Specific outcomes include: youths and caregivers are given ample opportunity to express themselves and to tell their stories during at least 75% of the ISP meetings. Further youth and family strengths and skill are addressed during at least 75% of ISP meetings. At least 75% of clients endorse positive cultural sensitivity/competence by CMOs and providers, services are provided in venues chosen by families at least 75% of the time, and evidence-based treatments are used at least 50% of the time. Other long-term strategy outcome expectations include the development of a provider panel offering a broad array of proven treatments and services that are offered in an integrated way by various agencies/providers (interagency collaboration is noted to have taken place at least 75% of the time). Another expected outcome of the implemented strategies is that preschool children and youths with moderate LOC needs have increased access to services. The expected outcome is that services are offered to 40 preschool children during the first clinical year.

Indicators measure each long-term outcome. Four measures will be utilized to monitor the integration of system of care principles and values into actual practice. The Multi-sector Service Contracts-Revised (MSSC-R) and The Cultural Competence and Service Provision Questionnaire (CCSP) track the actual services that were provided as well as the family's opinions about the cultural sensitivity/competence of the providers. The Checklist for Indicators of Process and Planning (ChIPP) measures the extent to which ISP teams demonstrate, during team meetings, the conditions necessary for the implementation of high-quality individualized service planning. In addition, the Wraparound Observation Form-Second Version (WOF-2) reflects fidelity to stated principles in the delivery of services based on the Wraparound approach to clients. Outcomes concerning the array of services will be substantiated in three ways: Part C Utilization Review plan (measurement of evidence-based treatments), Part D Utilization Review plan, which monitors and records high-end services for LOC IV youths, and the MSSC-R. Increased access for moderately affected LOC youth and preschoolers will be tracked via Part A of the Utilization Review plan, which monitors LOC and age of clients.

Youth/family outcomes describe changes in both clinical and functional dimensions of client behavior and affect. Improvements in child mental health measures should precede improvements in functioning within home, school, and special environments. Expected short-term outcomes include: externalizing behaviors statistically improve in 50% of LA-YES youths from the first testing period to the second, and 50% of youths with anxiety and/or depression problems experience statistically significan improvemtn from the first testing to the second. Long-term outcomes include improved functioning in school, reduced out of home placements, and reduced juvenile justice encounters. Positive changes in family stress represent a long-term outcome. The specific measurable outcomes are listed in the outline at the end of this section.

Indicators for these long-term outcomes include a host of national and local evaluation measures. The Child Behavior Checklist (CBCL and YSR) measures parent reported and youth (adolescent) reported change along multiple behavioral and emotional dimensions. The Education Questionnaire-Revised (EQR) provides useful data on school functioning. The Living Situations Questionnaire (LSQ) and Youth Situations Questionnaire (YSS) provide quantifiable information about the youth's functioning in general and within the home and neighborhood. The Delinquent Survey-Youth tracks juvenile justice contacts. The Caregiver Strain Questionnaire (CSGQ) and Brief Symptom Inventory (BSI) provide data about family functioning.

System outcomes will develop more slowly than program and youth/family outcomes. There are short-term outcomes, however, and they include improved capacity. Currently, six percent of the target population has access to services. LA-YES strategies are expected to increase capacity to 10% in the short run. The Enrollment and Demographic Information Form (EDIF) and the Part A Utilization Review plan will provide indicator data for the increased access outcome. In addition, short-term outcomes include the appropriate allocation and local use of resources (75% of LA-YES youths receive resources appropriate to their LOC level). This will be tracked by the Part C Utilization Review plan and the MSSC-R. Further, child and family satisfaction with care should improve in measurable ways rather quickly (ie, 75% of youths and families are satisfied with services received through LA-YES). The national survey instrument Youth Services Survey (YSS-F) will track family satisfaction.

Long-term system (infrastructure) changes must occur for program and youth/family changes to be sustained. The first outcome is an extension of the short-term outcome, improved access. However LA-YES strategies are expected to improve access beyond short-term expectations to 25% of the target population. Part A of Utilization Review will measure this. A second expected long-term outcome is that the public in the target area are more aware of mental health issues in children and adolescents and that mental illness stigmatization is diminished (10% of individuals surveyed are more aware of mental health issues in children and adolescents because of recent community education efforts). In addition, the parents and public are more aware of community/advocacy supports and services. (The measurable outcome is that 10% of the surveyed public will endorse an increased awareness of these supports and services.) Community surveys will measure

these. The third outcome is that partner collaboration leads to resource pooling for common treatment aims. The expectation is that at least two partner agencies invest resources in the LA-YES project by year 4. The LA-YES budget will reflect to what degree this expectation is met. The fourth expected outcome, that reimbursement and the reimbursement process for services delivered to the target population are equitable and manageable, grows out of the goal that reimbursement practices will encourage practitioners to work with individuals eligible for LA-YES services (specific expectations: Psychiatry services are reimbursed by Medicaid at a rate of at least 75% of the rate typically paid by third party commercial payors; Case management is reimbursed by Medicaid at a level that mitigates the need for LA-YES augmentation). The indicator for this last outcome will be LA-YES records reflecting Medicaid procedures for funding fee-for-service elements of Wraparound and of psychiatric services. To satisfy the expected outcome, Medicaid will reimburse for psychiatry, psychology, and Wraparound services at a rate that mitigates the need for LA-YES to pay for or augment payment for those clinical services. Further, LA-YES fiscal sustainability is a long-term expected outcome and will be reflected in the LA-YES budget. Finally, collaboration with families at all levels is an expected outcome, which will be measured with the Wilder Foundation Collaboration Scale.

a. Program Context

i. Outcomes

1. Short-Term
    a. The planning process identifies system of care principles and values (including the use of evidence-based, best-practices approaches, family involvement, services to younger clients, and the use of outcomes to redesign programs). They are incorporated into the process of program development
        i. Specific evidence-based treatments are identified for inclusion into the LA-YES process during the planning year
        ii. Policies and procedures outlining family involvement in the service delivery process will be developed during the first year
        iii. The ISP Practice Model will be designed during the planning year
2. Long-Term
    a. System of care principles and values are integrated into program practice
        i. Youths and caregivers are given ample opportunity to express themselves and to tell their stories during at least 75% of ISP meetings
        ii. Youth and family strengths are addressed during at least 75% of ISP meetings

iii. At least 75% of clients/families endorse positive cultural sensitivity/competence by CMOs and other providers
iv. Services are provided within venues chosen by family members in at least 75% of cases.
v. Services are judged to be individualized at least 75% of the time
vi. Evidence-based treatments are used in at least 50% of LA-YES cases

b. An increased array of services that are integrated and coordinated among agencies are offered in the least restrictive context
    i. Interagency collaboration is noted to have taken place at least 75% of the time
c. Moderately (functionally) impacted children/adolescents will receive services
    i. Services are offered to at least 150 youths with moderate LOC needs during the first clinical year
d. The program targets preschool children with target needs
    i. Services are offered to at least 40 preschool children during the first clinical year

ii. Indicators
1. Short-Term
    a. Completion of the Logic Model. Using the Logic Model to guide additional planning and incorporation of principles into practice (1a.i,ii, iii)
    b. The development of LA-YES Policies & Procedures that are consistent with system of care values and principles (1a.i, ii, iii)
2. Long-Term
    a. ChIPP (Outcome 2ai,ii) and WOF (2ai, iv,v, 2bi) measures will be randomly administered by family evaluators during ISP meetings. Outcomes will be tallied and reported.
    b. Utilization review, Part A: Recording of the number of youths served within each LOC (Outcome 2c.i) and recording of number and percentage of 3-6 year olds treated (Outcome 2d.i)
    c. Utilization review, Part C: measurement and recording of services used. (Outcome 2bi)
    d. National and Local evaluations: CCSP (Cultural Competence and Service Provision Questionnaire) (Outcome 2a.iii.) and MSSC-R (Multi-sector Service contracts-Revised) (Outcome 2aivnd 2b)

e. Utilization review Part D: measurement and recording of high-end services for LOC IV individuals for Outcome 2a.vi.)

b. Youth/Family Context

i. Outcomes

1. Short-Term

a. Improved child mental health and reduced child/adolescent distressing symptoms

i. Externalizing (negative) behaviors statistically improve in 50% of LA-YES youths from the first testing period to the second

ii. 50% of youths with primary anxiety and/or depression problelms experience statistically significant improvement from the first testing period to the second

2. Long-Term

a. Improved ability of LA-YES youth to function in his/her domains

i. Reduced out-of-home placements including state custody, hospitalization

1. 50% of OCS-referred youths experience no disruption in placement because of behavioral or mental health issues

ii. Improved functioning in school

1. 75% of clients are attending school or have graduated or obtained a GED
2. 60% of LA-YES youths experience fewer disciplinary actions (expulsion, suspension, detention) during the second testing period compared with the first
3. 60% of LA-YES youths present with better grades during the second testing period compared with the first

iii. Reduced juvenile court encounters

1. 65% of youths arrested during the first testing period experience a decreased number of arrests in the second testing period
2. 65% of youths experience fewer court apperances during the second testing period
3. 65% of youths experience fewer convictions during the second testing period

b. Improved family functioning and reduced caregiver stress

i. 60% of LA-YES families experience decreased stress during the second testing period compared to the first

ii. Indicators

1. Short-Term
    a. CBCL (Child Behavior Checklist) and YSR (CBCL for adolescents) for Outcome 1a.i and 1a.ii.
    b. Reynolds Adolescnet Depression Scale-Second Edition-Youth (RADS-2) and the Revised Children's Manifest Anxiety Scales (RCMAS) (1a.ii)
2. Long-Term
    a. National and local evaluation measures administered to a sample of the overall LA-YES population. These instruments measure both clinical (symptom) and functional outcomes: EQR for Outcome 2a.ii.1, 2, and 3. (Education Questionnaire-Revised); LSQ for Outcome 2a.i.1 (Living Situations Questionnaire); YSS for outcome 2a.i. (Youth Services Survey); Delinquent Survey-Youth for Outcome 2a.iii. 1, 2, and 3; CSGQ for Outcome 2b.i. (Caregiver Strain Questionnaire); BSI (Brief Symptom Inventory) for Outcome 2b.i.

c. System Context

i. Outcomes

1. Short-Term
    a. Increased capacity and improved access
        i. From 6% (ie, 6% of the target population currently has access to mental health services) to 10% (ie, capacity will be increased such that 10% of the target population has access to mental health services)
    b. Resources are appropriately allocated and utilized locally
        i. 75% of LA-YES youths receive services appropriate to their LOC need
    c. Child and family satisfaction with care is improved
        i. 75% of youths and families are satisfied with services received through LA-YES
2. Long-Term
    a. Increased capacity and improved access
        i. From 10% to 25%
    b. The public in the target area are more aware of mental illness in children and adolescents and stigma has decreased; public are more aware of community/advocacy services and supports
        i. 5-10% of individuals surveyed are more aware of mental health issues in children and

adolescents because of recent community education efforts

ii. 5-10% of individuals surveyed endorse that they are more aware of existing community/advocacy services and supports

c. Partners broker services and pool resources to provide services for the target population

i. At least 2 partner agencies invest resources in the LA-YES project by year 4

d. Reimbursement and the reimbursement process for services delivered to the target population are consistent with the provision of quality services and system of care values/principles

i. Psychiatry services are reimbursed by Medicaid by a rate of at least 75% of the rate typically paid by third party commercial payers

ii. Case management is reimbursed by Medicaid at a level that mitigates the need for LA-YES to pay for or augment the payment for case management services

e. LA-YES is sustained fiscally by Year 6

f. Collaboration with families occurs at all levels

i. At least 50% of parents endorse positive collaboration

g. System of care is transported from the 5 parishes initially designated to the other parishes within Louisiana

ii. Indicators

1. Short-Term

a. Utilization review Part A: measurement and recording of the number of clients served, the LOC percentages, and the portal of intake; Enrollment and Demographic Information form (EDIF) for Outcome 1a.i

b. Utilization review Part C: measurement and recording of resource usage for each LOC for Outcome 1b.i

c. National and Local evaluations: MSSC-R (Multi-sector Service contracts-Revised) for Outcome 1b.i; YSS-F (Youth Services Survey) for Outcome 1c.i

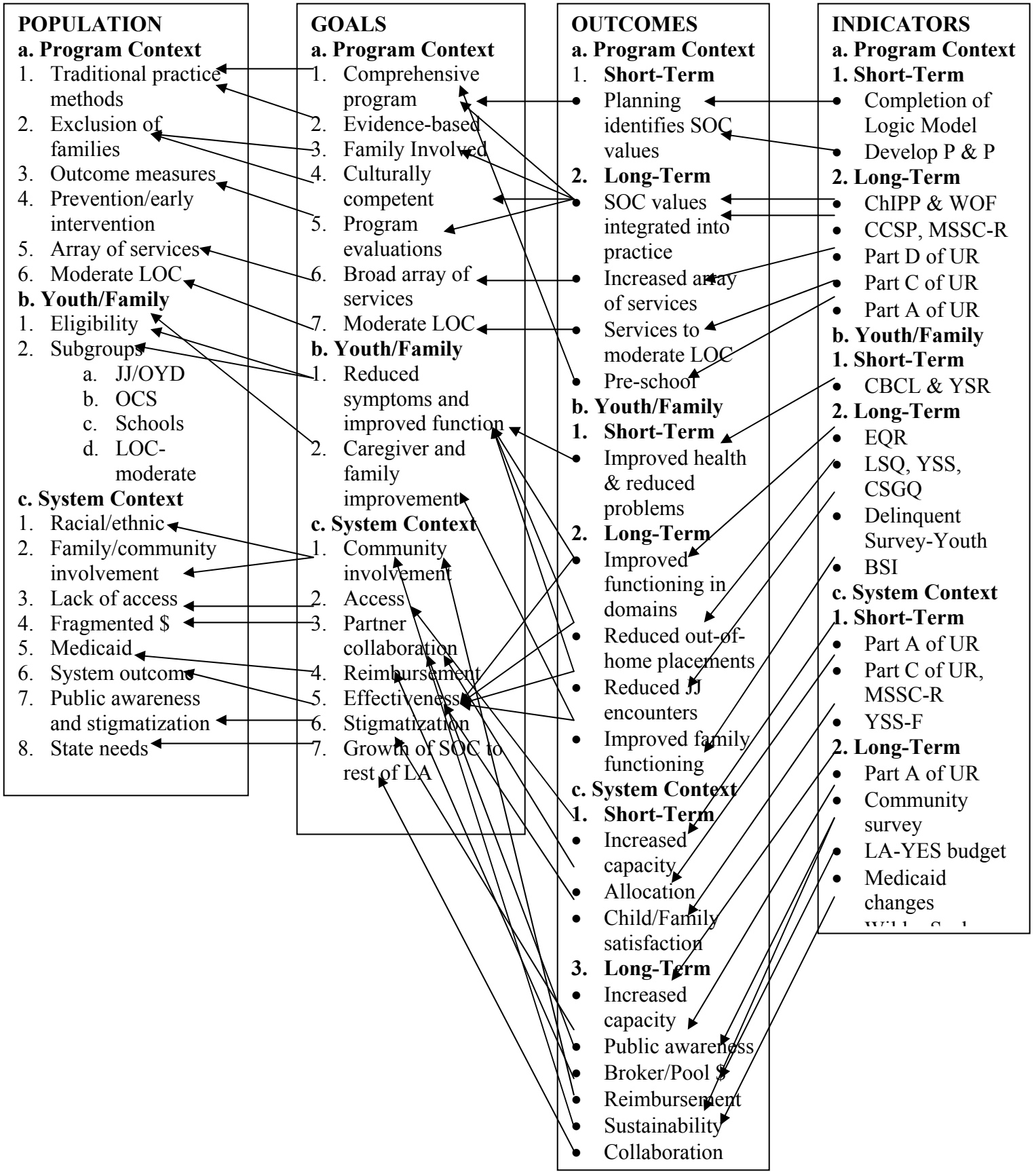
2. Long-Term

a. Utilization review Part A: measurement and recording of the number of clients served, the LOC percentages, and the portal of intake for Outcome 2a.i

b. Community survey measuring awareness of mental illness within the target population and stigmatization for Outcome 2b.i,ii

c. LA-YES budget reflects resource pooling by partner agencies (Outcome 2c.i and 2e)
d. Medicaid funding policy (2d.i, ii)
e. Wilder Foundation Collaboration Scale (2fi)

The Logic Model Chart (an abreviated version of the outlines within each stage) is presented on the following page. It demonstrates the connection between Population, Goals, Outcomes, and Indicators.


POPULATION
a. Program Context
1. Traditional practice methods
2. Exclusion of families
3. Outcome measures
4. Prevention/early intervention
5. Array of services
6. Moderate LOC
b. Youth/Family
1. Eligibility
2. Subgroups
a. JJ/OYD
b. OCS
c. Schools
d. LOC-moderate
c. System Context
1. Racial/ethnic
2. Family/community involvement
3. Lack of access
4. Fragmented $
5. Medicaid
6. System outcome
7. Public awareness and stigmatization
8. State needs
GOALS
a. Program Context
1. Comprehensive program
2. Evidence-based
3. Family Involved
4. Culturally competent
5. Program evaluations
6. Broad array of services
7. Moderate LOC
b. Youth/Family
1. Reduced symptoms and improved function
2. Caregiver and family improvement
c. System Context
1. Community involvement
2. Access
3. Partner collaboration
4. Reimbursement
5. Effectiveness
6. Stigmatization
7. Growth of SOC to rest of LA
OUTCOMES
a. Program Context
1. Short-Term
• Planning identifies SOC values
2. Long-Term
• SOC values integrated into practice
• Increased array of services
• Services to moderate LOC
• Pre-school
b. Youth/Family
1. Short-Term
• Improved health & reduced problems
2. Long-Term
• Improved functioning in domains
• Reduced out-of-home placements
• Reduced JJ encounters
• Improved family functioning
c. System Context
1. Short-Term
• Increased capacity
• Allocation
• Child/Family satisfaction
3. Long-Term
• Increased capacity
• Public awareness
• Broker/Pool $
• Reimbursement
• Sustainability
• Collaboration
INDICATORS
a. Program Context
1. Short-Term
• Completion of Logic Model
• Develop P & P
2. Long-Term
• ChIPP & WOF
• CCSP, MSSC-R
• Part D of UR
• Part C of UR
• Part A of UR
b. Youth/Family
1. Short-Term
• CBCL & YSR
2. Long-Term
• EQR
• LSQ, YSS, CSGQ
• Delinquent Survey-Youth
• BSI
c. System Context
1. Short-Term
• Part A of UR
• Part C of UR, MSSC-R
• YSS-F
2. Long-Term
• Part A of UR
• Community survey
• LA-YES budget
• Medicaid changes

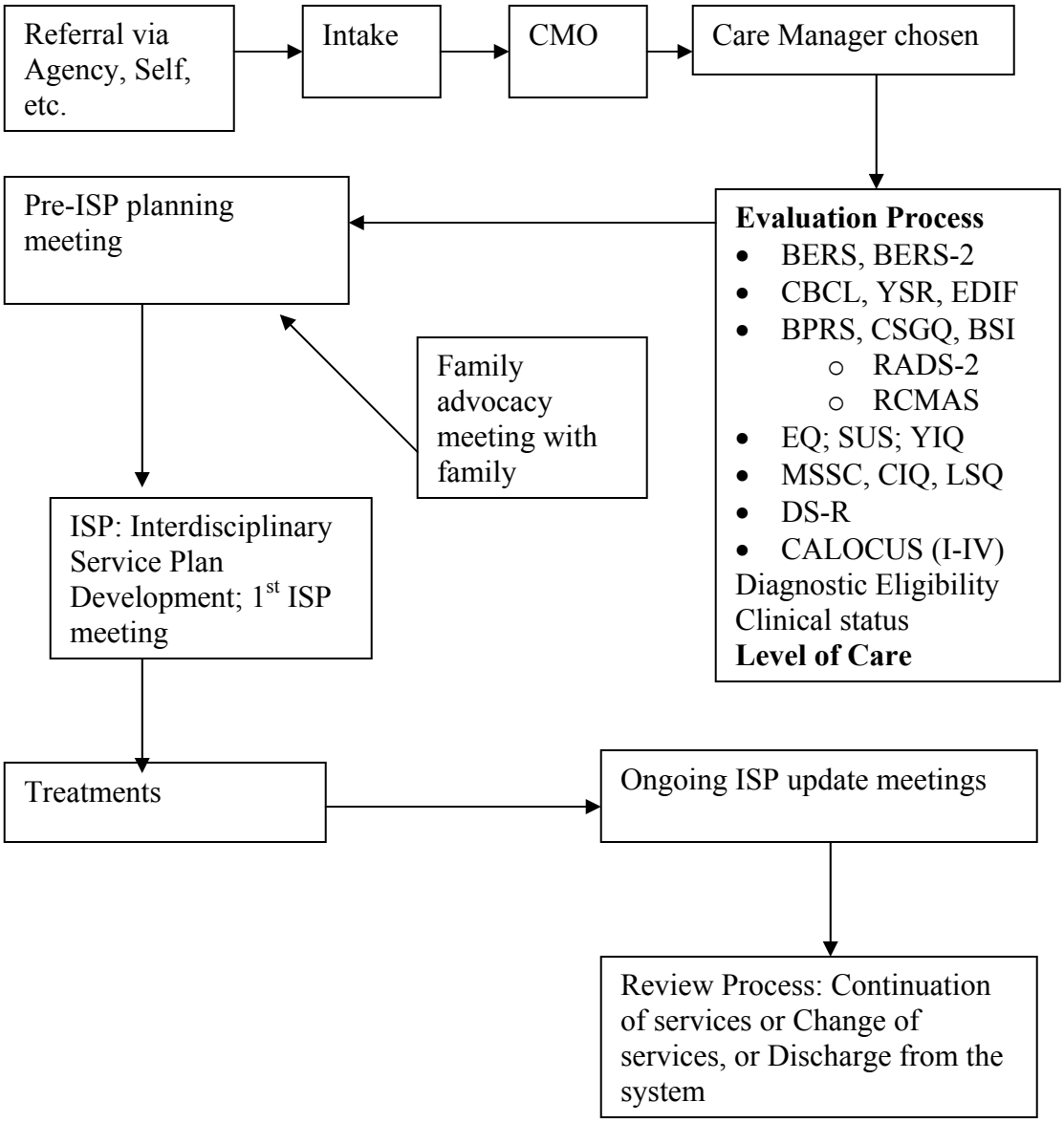
7. (Stage 8) System of Care Strategies

a. Local service delivery-service provision

Our principle strategy concerns the creation of a service delivery system that meets the needs of the target population. This includes the development of a plan that describes the structures necessary for care consistent with system of care values. The plan should also describe client flow through the care system. In addition, this strategy includes the infrastructure development necessary to support the vital structures. These include the development of policies and procedures for CMO functioning and provider behavior, credentialing, and other related processes.

The care plan calls for a coordinated system with each partner (juvenile justice, child welfare, education, and mental health). Clients will be referred to a (CMO) case manager who will establish the first face-to-face meeting with youth and family within 4 days of the referral. Eligibility determination, intake, the evaluation process, level of care determination, the ISP and pre-ISP processes, treatment and outcome assessment will proceed according to the Care Plan algorithm. A diagrammatic representation of the client flow through the system is presented in Figure 2.

CARE PLAN ALGORITHM (Figure 2)



REFERRAL

Clients will be referred to the LA-YES clinical program by our partner agencies/systems: juvenile justice (~125 referral during the first year), education (~125), mental health (~50), child welfare (~125), and Children's Hospital (~25). The LA-YES contact person within the partner systems will identify suitable candidates and then will discuss possible referral to LA-YES with the youth and parents/guardians. An outline of the intake, assessment and treatment procedures will be explained. If the youth and parent(s)/guardian(s) agree, the contact person will fill out the LA-YES Intake form and will fax it to the CMO (Fax #:). If there are any problems or if the contact person would like to discuss the referral, he/she will call the CMO (Telephone #:) to discuss the referral with the (on call) Intake worker (Care Manager).

The LA-YES contact person with the Region 1 mental health center system will refer individuals using the mechanism described in the previous paragraph. The clients referred by the mental health center contact person will be randomly chosen from a list of individuals who have applied for mental health center services, but who were found to be ineligible for services because of insufficient severity regarding level of care needs (in accordance with mental health center policy).

A mechanism will be devised for youth/parents to self-refer. Five percent (n=23) of intakes will be reserved for self-referral. Prior to its development, though, a companion mechanism must be created by LA-YES and the CMOs to refer those individuals applying for services with LA-YES, but who cannot be served, for care outside of LA-YES.

INTAKE

The case manager (intake worker) will review the referral to determine eligibility. Within 4 workdays of receiving the faxed referral (Intake form), the CMO Intake worker (Care Manager) will phone the parent/guardian of the youth to make initial contact. The Care Manager will explain briefly the Intake process and will arrange a time/date/venue for the first meeting with the youth, parent(s)/guardian(s), and other individuals whom the youth/parent would like to attend the initial meeting.

During the first meeting, several forms must be completed. These include consent for treatment, release of information, consent for research, and other possible consents (eg, videotaping of ISP). The Care Manager informs the client and parents of their specific rights and procedural safeguards, including determining if each client's family freely accepts services as optional. The Care Manager will provide the client and family with sufficient information about other available services to meet their needs to ensure freedom of choice. The client's/family's rights to terminate at any time and seek other services or to secure second opinions will be explained.

In addition, the Care Manager will complete (during or immediately following the meeting) the EDIF, the CALOCUS, and the BPRS. The BSI will be filled out by the

youth's parent/guardian (while the Care Manager is interviewing the youth) and the YSR will be filled out by the youth (if 12 years of age or older while the Care Manager is interviewing the parent/guardian).

During the course of the first meeting, the Care Manager will conduct a psychosocial interview and will record the results (in a standard psychosocial format). The data gleaned from the psychosocial interview will be sufficient for the Care Manager to subsequently complete the forms noted in the preceding paragraph (and thus to determine the youth's level of care). Additional Intake interviews will be scheduled if necessary to obtain the desired information (ie, if the information cannot be obtained during the first interview).

The Care Manager will explain that a (parent) member of the Evaluation Team will contact the parent/guardian to set up a meeting so that the National Evaluation measures (except for the EDIF, which will have been completed by the Care Manager) can be administered and completed. The Evaluation Team member will arrange a time/date/venue for the administration of the National Evaluation measures when contact is made with the youth's parent/guardian.

EVALUATION

The National Evaluation measures administered by the Evaluation team member will include: Multi-Sector Service contacts (MSSC-R); the Delinquency Survey-Revised (DS-R); the Caregiver Information Questionnaire (CIQ; the Living Situations Questionnaire (LSQ); the Caregiver Strain Questionnaire (CGSQ); the Youth Information Questionnaire (YIQ); the Education Questionnaire (EQ); the Substance Use Survey (SUS); the Caregiver and Youth versions of Behavioral and Emotional Rating Scale (BERS, BERS-2); the Reynolds Adolescent Depression Scale-Second Edition (RADS-2); and the Revised Children's Manifest Anxiety Scales (RCMAS). (The Care Manager will administer the EDIF during the Intake interview.)

The local evaluation will consist of the YSR (CBCL completed by adolescents), Brief Symptom Inventory (BSI), and Parent Stress Index (PSI).

A Psychiatric interview will be scheduled when 1) the Care manager determines that symptoms are present that require a psychiatric evaluation or 2) the youth's level of care is determined to be Level 3 or 4 (CALOCUS Composite Score of 23+ or CALOCUS Dimension I or II scores of 4 or 5).

Regarding outcome, the Evaluation process will lead to the production of 1) a youth and family strengths list, 2) a problem list with diagnoses, 3) an integrated impression of the youth and family situation, and 4) a level of care (LOC) determination.

LEVEL OF CARE (LOC)

Four levels of acuity/severity have been described. They are based on the child's needs and the characteristics of his/her behaviors and are determined by the CALOCUS. Each level defines types of services that are available for the child and family. (Percentage designations following the Levels [listed within parentheses] indicate the predicted percentage of LA-YES youth within each Level.)

1. **Level 1** (offered within the typical family setting and designed to support and maintain the child/adolescent within the family setting; 4-6% of assessed youth)
    a. CALOCUS Dimensional designation
        i. Dimension I: 2 (or lower)-Some risk of harm
        ii. Dimension II: 2 (or less)-Mild functional impairment
        iii. Dimension III: 2 (or less): Minor Co-morbidity
        iv. Dimension IV: 2 (or less): Mildly stressful environment
        v. Composite Score: 10-16
    b. Individual needs
        i. Routine guidance and supervision to ensure safety and security
        ii. Affection and nurturance
        iii. On-going contact with family members
        iv. Access to appropriately designed and delivered health care
    c. Services
        i. Case/care Management
        ii. Assessment and evaluation
        iii. Mentoring to facilitate resilience
        iv. Parenting/family skills training/family support and education
        v. Transportation
        vi. Parent and family mentor
        vii. Recreational/social mentor services

2. **Level 2** (offered within the family setting with structured support/services; 45-47% of assessed youth)
    a. CALOCUS Dimensional designation
        i. Dimension I: 3 (or less)-Significant risk of harm
        ii. Dimension II: 3 (or less)-Moderate functional impairment
        iii. Dimension III
            1. 3 (or less)-Significant Co-morbidity
            2. 4 (or less)-Major Co-morbidity
        iv. Dimension IV: 3 (or less)-Moderately stressful environment
        v. Composite Score: 17-22
    b. Individual needs: in addition to Level 1 needs
        i. Increased guidance and supervision to ensure safety and a sense of security
    c. Services: in addition to Level 1 services
        i. Wraparound approach
        ii. Family preservation
        iii. Family therapy
        iv. Respite/Planned respite

v. Community supervision
vi. In home behavioral treatment (ACT)
vii. Family assessment
viii. Group therapy
ix. Individual therapy
x. Behavioral management services
xi. Integrated Cognitive Behavioral Therapies
xii. Integrated treatment for youth with both a developmental disability and a mental illness
xiii. Medication follow-up/psychiatric review
xiv. Trauma-based services/treatment
xv. Nursing services

3. **Level 3** (offered within the family setting by providers with specialized training; 45-47% of assessed youth)
    a. CALOCUS Dimensional designation
        i. Dimension I: 4-Serious risk of harm
        ii. Dimension II: 4-Serious functional impairment
        iii. Dimension III: 5- Severe Co-morbidity
        iv. Dimension IV
            1. 4-Highly stressful environment
            2. 5-Extremely stressful environment
        v. Composite Score: 23-27
    b. Individual needs: in addition to Level 2 needs
        i. Access to responsive, emergency services
        ii. 24 hour monitoring
    c. Services: in addition to Level 2 services
        i. Crisis intervention/stabilization services
        ii. Intensive Case Management
        iii. Day treatment
        iv. Crisis respite
        v. Therapeutic foster care

4. **Level 4** (offered within family setting [as much as possible] by caregivers with specialized training to provide intense therapeutic and rehabilitative supports; the highest degree of structure necessary to protect the child; 2-3% of assessed youth)
    a. CALOCUS Dimensional designation
        i. Dimension I: 5-Extreme risk of harm
        ii. Dimension II: 5-Severe functional impairment
        iii. Composite Score: 28+
    b. Individual needs: in addition to Level 3 needs
        i. Access to 24 hours supervision
        ii. 24 hour care management
    c. Services: in addition to Level 2 services
        i. 24 hour supervision
        ii. Residential Care

iii. Hospitalization

SUPERVISION

After the evaluation measures have been collected, scored, and recorded (returned by the National Evaluation team) by LA-YES/CMO, the Care Manager will meet with the LA-YES Clinical Director and/or Care Coordinator to discuss the findings, impressions, and plans for the ISP. On-going supervision will follow the guidelines developed in the Supervision Policy and Procedures. Active coaching will be utilized to ensure fidelity to the Wraparound/ISP philosophy.

PRE-ISP

The pre-ISP meeting with youth, family members, individuals supporting family members, and youth/family advocate. The advocate will confer with the case manager before the first ISP meeting. Wraparound/system of care philosophy will be explained/discussed, especially family-centered, strengths-based approaches. Expectations for the system, the care manager, and the family are explicated and discussed. Ways of monitoring the plan (including the frequency of ISP meetings) and modifying it as necessary will be discussed and agreed upon.

ISP

The ISP Practice Model has been developed and will be presented to and discussed with Case Managers/CMOs. Case managers, families, and providers will clarify, during the first ISP meeting, the particular meeting structure and techniques that will be followed. This includes the development of long-term goals (for the client's ISP process) as well as intermediate goals and indicators of progress. Tasks (plans) will be linked to the goals. A crisis plan will be the first task to be completed.

ISP PRACTICE MODEL

Team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner consistent with the value base of ISP

A. Team adheres to meeting structures, techniques, and procedures that support high quality individualized planning.
    i. A long-term goal or mission is agreed upon.
    ii. Specific intermediate goals and observable indicators (performance criteria) of progress towards goals are clearly defined to assess progress toward, or achievement of a goal.
    iii. Action steps or goals are derived for other family members, not just the identified child.
    iv. Tasks, strategies and action steps are linked to intermediate goals, and responsibilities for performing each task is assigned.

v. Progress on each action, goal and/or sub-goal is monitored and/or revisited in subsequent meetings, and strategies for achieving the goals are altered at needed.
vi. Team members report on activities or progress relevant the plan.
vii. Develop a crisis plan for the child and family with a goal structure with action steps clearly defined, and the crisis plan should be reviewed and revisited in subsequent meetings.
viii. Key team members are present at (most) team meetings, prepared to make decisions or commitments, and participate collaboratively.
ix. Team generates a written agenda or outline for the meeting that provides an understanding of the overall purpose of the meeting as well as the purpose of the major sections of the meeting.
x. Team considers several different strategies for meeting a need or goal and considers and prioritizes several different goals.
xi. Team maintains a record of all its work that is distributed to all members.
xii. Team creates and maintains a plan that guides its work.
xiii.

B. Team processes are family and team-driven
C. Team considers multiple alternatives before making decisions.
    i. Generate multiple goal, strategy and solution options through problem solving, open-ended thinking and brainstorming and choose among, rather than committing to the first solution to increase likelihood that it is culturally competent and family driven.
    ii. Broaden perspectives of exchanging information or ideas
    iii. Be aware of tendency to rely on traditional, categorical services
    iv. Tailor community service or activity to meet the specific needs or goals of the child or family.
    v. Provide access to regular community service or support.

D. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families.
    i. Provide opportunities to promote the family's perspective.
    ii. The team works as a family-centered process, being driven by the family's own sense of strengths, needs and priorities.
    iii. The family's choice should guide decision-making regarding services and supports accessed to meet the team's goals.
    iv. The family should be given the opportunity to speak first and last during discussions and check back with the families after any decision in order to accurately reflect the family's perspective.
    v. Include the family's strengths, needs, and priorities in the goals.
    vi. Provide an opportunity for the families to "tell their story;" the narrative provides the team with information as to family history, experiences, current situation, and the families hopes, strategies, resources, and goals.

vii. Create a team atmosphere whereby family members and natural supports feel valued, and safe to speak openly and honestly, and encourage their engagement in the process by valuing input, building agreement, appreciating strengths, and reflecting cultural competence.
viii. Team members use appropriate skills such as active listening, reflecting, and summarizing to help demonstrate valuing of each team member's input.

E. Team uses structures and techniques that lead all members to feel that their input is important and valued.
    i. Promotes fair procedures during discussion and decisions making. Provide a sense of equity (fairness) in terms of discussion and decision making processes by valuing and respecting each member and their input.
    ii. Increase equity of participation by families, natural supports, and nontraditional supports by providing an opportunity for each team member to provide an opinion or input on a decision, use reflections and summarizations, and record each members idea or suggestion.
    iii. Provide an opportunity for the youth to be an integral part of the team.

F. Team builds agreement around individualized plans despite differing priorities and diverging mandates.
    i. Use controversy or differing opinions as a beneficial source of creativity and learning.
    ii. Establish clear, shared goals that will promote cooperation to advance the goal.
    iii. Use the shared goals as a means to build cohesiveness and promote teamwork, and reminding of the shared goals and how conflict will negatively impact the families' goals.
    iv. Team members demonstrate consistent willingness to compromise or explore further options when there is disagreement.

G. Team builds an appreciation of strengths of the children, their families, and members of the team.
    i. Provide opportunity to empower the family during the team process by encouraging and valuing their participation and ideas, and input is acknowledge either verbally or written recording.
    ii. Maintain a strengths perspective.
    iii. Team explicitly builds an understanding of how caregiver strengths contribute to the success of the team mission or goals.
    iv. Team explicitly builds an understanding of how youth strengths contribute to the success of team mission or goals.
    v. Team provides multiple opportunities for community team members and natural support people to participate in significant areas of discussion and decision-making.

vi. Team draws attention to and creates positive atmosphere around accomplishments or improvements.

H. Team planning reflects cultural competence, building on unique values and preferences of the children, families, and their communities.
   i. Adhere to the structures, techniques, and procedures that support the family's values and the family's voice.
   ii. Include a number of natural supports, community based, community experience, and community supports to promote cultural competence.

I. The team is committed, unconditionally, to serve children and their families.

TREATMENT

Services will be provided in accordance with Level of Care need determined by the CALOCUS. The specific treatments are listed (above) within the Level of Care section. Providers (of the treatments) will attend ISP meetings. Providers will operate in accordance with SOC values.

Treatment usage predictions are based on expected client levels of care. The services reserved for LOC IV youth only should be used with approximately five percent of the clients (~23 in year one). The services that are reserved for LOC III and IV youths should be used approximately 50% of the time. Because services utilized by LOC I and II clients will also be available for all clients, many of those services will be highly utilized (by over 75% of clients.

OUTCOME MEASURES

1) National Evaluation: The parent evaluator will administer 28 of the 29 instruments following the initial meeting between the case manager and the youth/parent(s). The case manager will administer EDIF during the first meeting with youth/parent(s). The National Evaluation team will score the measures and send the results to the local team electronically (for clinical and local evaluation use).

2) Local Evaluation: During the first visit with the youth/parent(s), the case manager will ask the parent to complete the BSI and the youth (if 12 years or older) to complete the YSR. The case manager will complete the BPRS following the psychosocial interview. The case manager will score these instruments following the first meeting.

3) Utilization Review: 4 levels of utilization review will be used during the clinical process to monitor fidelity to the established plan.

A) Each CMO will track and report on a monthly basis (through the case managers) to the clinical director information about several variables that will be used to monitor intake: age and gender of the clients served, Level of Care of the clients, portal of entry for the clients, and the number of clients (currently) served by each CMO. At least 40% of the clients should be 12

years of age or younger (and/or 13 years or older). Each gender should be represented by at least 40% of the clients. No one CMO should have more than 60% of the assigned LA-YES cases. Finally, at least 40% of the clients should be assigned LOC II, at least 40% should be assigned LOC III, and no more than 5% should be assigned LOC IV. Based on the information collected, intake will be managed so that overall numbers (for the variables monitored) will comply with stated goals.

B) A parent evaluator will attend a sample of ISP meetings (3/15) and will complete the WOF-2 and the ChIPP. The clinical director and/or his designee as a means of monitoring fidelity to the Wraparound process and the ISP process will review these rating scales. The clinical director will offer feedback to the CMOs and the case managers.

C) For supervision each week, the case manager will complete a form that tracks the (case manager's) number of current cases, the frequency of ISP meetings for each case, each youth's LOC (tracking of all changes in LOC), use of natural supports and flexible funds, removal of any client from the home, use of in-home services, and other variables.

D) Each case manager will report weekly on all Level IV cases: the use of high-end services (respite, therapeutic foster care, hospitalization, and day treatment). The case manager will offer an analysis of the cost of each (high-end) service.

b. Development of a Strategic Plan for the delivery of clinical services during the latter part of the planning year and during the first year of clinical operations (July, 2004-September, 2005)

The two major clinical tasks for the coming year are the implementation of the care plan and accompanying processes (through the CMOs) and the development of a provider panel (and supportive infrastructure). Each has a number of associated tasks, some of which will be completed during the coming year and some of which will require action throughout the life of the project.

CMO related activities begin with the anticipation and development of needed policies and procedures. These include mechanisms describing the use of LA-YES funds as flexible funds and as selectively used inducements to encourage provider panel development. In addition, ASO expectations of the CMOs should be spelled out: involvement in training and supervision; development of the elements of the service delivery system including fidelity to the Wraparound approach, an intake process with a single point of entry, national and local evaluation processes, ISP, care management, and CMO involvement with provider panel recruitment; and include details about the CMOs' commitment to system of care values.

Policies and procedures regarding family member involvement in service delivery, in addition to those describing the monitoring non-clinical behavior of the CMOs by the ASO, must be developed and implemented. The need for additional policies and procedures will emerge as the year progresses.

The next step in the process will be the negotiation of contracts with the agencies chosen to serve as CMOs and certified by DHH. Immediately upon the completion of that process, the ASO will begin discussions with the CMOs about ASO expectations (regarding care plan implementation) and about the initial training process. The initial training, the specifics of which will be developed in concert with the CMOs, will be organized in a five day, conference-style format. The proposed curriculum consists of:
1) Introduction and Expectations of the CMOs (2 hours; Dr. Dalton)
2) Behavioral Techniques and Integrated CBT (cognitive behavioral therapy) (2 hours; Dr. Pellerin)
3) Wraparound: Philosophy and details (1.5 hours; Dr. Pellerin)
4) ISP (Individualized Service Planning): Practice Model, Collaboration, Acquiring services/supports, etc (1.5 hours; Dr. Pellerin)
5) Cultural Competence (9 hours; Ms. Ford)
6) Crisis management (~2 hours: **No presenter has been identified)**
7) Parents present their "stories" (3 hours; Parents and Dalton)
8) Family competencies (3 hours; Dr. van Beyer and Dr. Daruna)
9) Evidence-based treatments
    Mentoring (1 hour; **No presenter has been identified**)
    Respite (1 hour; **No presenter has been identified**)
    Brief Functional Family Therapy (1 hour; **No presenter has been identified**)
    In-home services (ACT) (1.5 hour; Jennifer Buras 1-1.5 hours **No other presenter has been identified**)
    MST (1.5 hours; Ms. Christine Bonura)
10) Case Management (1.5 hours; Mr. Barry Chauvin)
11) CALOCUS (2-3 hours; Dr. Pumariega)

ASO expectations of the CMOs regarding the implementation of the Care Plan include assisting in the development and implementation of an intake process, case management, involvement in the national and local evaluation, ISP, and supervision and Utilization Review (based on the LA-YES policies and procedures described previously).

The development of the provider panel is the second major LA-YES clinical task for next year. This will include a credentialing process for individual and provider agencies. Credentialing describes the development of appropriate policies and procedures, which articulate the actual process (checking license, insurance, etc). The involvement of the CMOs in this process will be negotiated with the CMOs. Priority needs for the panel include: psychiatry, in-home respite, crisis management, mentoring, therapeutic foster care, assertive community treatment, brief functional family therapy, and CBT/DBT/MST.

ACTION ITEM
Relevant Policies & Procedures
Negotiating and signing contracts
Training and expectations
Care Plan Implementation

	Intake: Single Point of Entry
	Case Management: Hiring
	National and Local Evaluation
	ISP & ISP Practice Model
	Supervision and UR
ASO oversight of non clinical services	
Credentialing	
	Policies & Procedures
	Process
	Licensure, Insurance, etc.
Services	
	Psychiatry
	In-home Respite
	Crisis Management
	Mentoring
	Therapeutic Foster Care
	Assertive Community Treatment
	Brief Functional Family Therapy
	CBT/DBT
	MST

c. Local infrastructure development

- **i.** Governance
- **ii.** Technical Assistance
- **iii.** Social Marketing

d. Strategies respond to outcomes

The purpose of this section is to describe how the chosen strategies provide the hoped-for outcomes. It relates the components of the plan to the outcomes on one hand and to the indicators on the other. In particular, the components of the LA-YES strategies are designed to provide the outcomes and are measured by the indicators.

Program context short-term outcomes are addressed through planning, and through the development of the ISP Practice Model and clinical practice policies and procedures. Long-term program context outcomes are provided through the implementation of the care plan. For example, integration of system of care values and principles is addressed by the development and implementation of the ISP Practice Model, through CMO and provider training and monitoring regarding cultural competence, by applying the care plan within community venues, and through the development and use of evidence-based treatments. The increased array of services is achieved through provider panel development and negotiations with Medicaid. (Strategies for Medicaid negotiation will be developed via the implementation of theTechnical Assistance Plan.) Improving access for individuals with moderate severe emotional disturbance (SED) needs as well as for

preschoolers will be accomplished through the Utilization Review Part A Plan. (Utilization Review Part A is both an implementation strategy and an indicator.)

Short-term and long-term Youth/Family outcomes are provided by the treatments listed in the care plan. The implemented treatments results provide the indicator measures.

System outcomes are also realized throught the various plans. The development of an intake process that is organized around LA-YES partner agencies will help ensure increased access. Implementation of the Utilization Management system will help ensure the appropriate allocation of services. Hopefully, the implementation of the care plan will lead to youth and family satisfaction.

Long-term outcomes are provided through multiple means. The social marketing plan is designed to increase awareness and decrease stigma. The Technical Assistance Plan will help develop strategies for accomplishing the brokered/pooled funds outcome as well as the Medicaid reimbursement outcome. Both the care plan and the social marketing plan will increase family collaboration. Planning by the Louisiana Office of Mental Health will assist in the transportation of system of care approaches to the remainder of the state.